Case record

Submitted to the Dr M G R Medical University in partial fulfillment of the requirement for the **Diploma in Psychological Medicine** examination 2010

Dr Ranjith P
TN Medical Council Regn. No. 82907

ACKNOWLEDGEMENT

Mrs Sushila Russell and **Ms Archana Padmakar**, Clinical Psychologists, Department of Psychiatry, for their guidance and supervision.

I express my gratitude to **Dr K S Jacob** (Professor and Head of the Department of Psychiatry), **Dr Deepa Braganza** (Professor and Head of Psychiatry Unit – II), and Dr **Paul S S Russell** (Professor and Head of Child and Adolescent Psychiatry), for allowing me to undertake assessments on patients under their care.

I express my sincere thanks to all the patients, who had co-operated for the assessments.

CONTENTS

CASE RECORD - 1

Name : Mr.A.S.

Age : 15 years

Sex : Male

Education : 9th Standard

Marital Status: unmarried

Informants : mother

Reliability : good

Chief complaints:

Episodes of possession by various persons

Pain and loss of sensation of both legs

Hearing of nonexistent voices

Duration: 2 months

Mode of onset: Acute

History of presenting illness:

He presented with a 2 months history of multiple episodes of unconscious spells followed by possession of his body by spirits which he claimed to be that of his father and grandmother, who were no more. The episodes would last for 1 to 2 hours. During the episodes he would speak like his father and grandmother. He also describes that during these episodes he could clearly hear his father talking to him and advising him, following

which he would reply to the voices. The illness apparently started after a quarrel with his mother over his multiple relationships with several girls in his school and locality. He had not been going to school during these days. There was a significant deterioration in his academic performance in the last 2 years. His sleep was decreased and appetite was also decreased. There was no history of delusions, manic symptoms, or of substance use.

Treatment History

He was taken to various hospitals and magico-religious treatment was also sought. Elsewhere he was given 20mg am od of C.Fluoxetine for a period of 1 month. However no improvement was noticed.

Family History

He is the only child, born of a non-consanguineous marriage. His father was a businessman and died 8 years back when he committed suicide(?depression).His mother is a 35 years old lady who is looking after the father's business. His mother was diagnosed to have a history of adjustment reaction, brief depressive disorder during her pregnancy.

Birth and Development History

His was a full term delivery, delivered by caesarean section. There were no history suggestive of perinatal asphyxia.. His developmental milestones were normal.

Education History

He is currently studying in 9th standard with English as his medium of instruction. His academic performance was reportedly poor.

Sexual history

He had heterosexual orientation. No masturbatory guilt.

Premorbid Personality

He was described to be sociable and an outgoing person. He had a strained relationship with his peers. He was described to be a person who wanted to be dominant and authoritative. He had hobbies like playing cricket, watching movies and was very interested in riding his bike.

Physical Examination

His vital signs were stable and systemic examination was within normal limits. All laboratory investigations were within normal limits.

Mental Status Examination

He was moderately built, well nourished. Eye contact was made and maintained and rapport was established without difficulty. Higher mental functions were normal. Thought content revealed stressors related to his poor performance in academics. He admitted hearing his father's voice talking to him and advising him when he had the episodes. His mood subjectively was depressed and objectively he appeared anxious. He had partial insight into his problems.

Differential Diagnosis

1.Acute Schizophrenia like psychosis

2.Dissociative disorder

Aims of Psychological Testing

1. To clarify symptomatology, psychopathology and diagnosis
2. To identify conflicts that will help in psychosocial intervention

Tests administered

1. Sack's Sentence Completion Test

2. Draw a Person Test

3. Thematic Apperception Test

4. Rorschach Ink Blot Test

Rationale for Psychological Testing

The **Sacks Sentence Completion Test** is a projective test developed by Dr Sacks and Dr Levy. It consists of 60 partially completed sentence to which respondent adds endings. The respondent projects the attitudes towards a personal experience of life. It helps to elicit ideas of self-perception and to evaluate the patient's adjustment in interpersonal relationships and also his self-concept to aid in the management of his illness and to counsel family members.

The Draw a Person test is a projective test found useful in providing an understanding of the patient's personality as well as ascertaining the presence of psychopathology.

The TAT was administered to throw light on patient's personality and interpersonal relationships.

The Rorschach was done to find details of psychopathology and psychodynamics.

Behavioural Observations

The patient was motivated for testing. His comprehension of instructions was adequate.

Test findings

On SSCT patient revealed significant conflicts and disturbances in the domain of family relationships especially with his mother, guilt associated with sexual relationships, negative attitude towards opposite gender and the distress associated with poor performance in academics.

DAPT – The drawings were neat with great attention given to each detail. All body parts were present. Hands were shown facing outward. He drew a boy having 6 fingers on one hand, whom he identified as his friend who performed well in his academics. The female figure was portrayed as a beautiful lady whom he wished to marry. His verbalizations on the drawing indicated feelings of low self-esteem and difficulty in forming relationships with own gender, preferring the company of women.

TAT- There was adequate productivity in terms of responses. All were descriptive stories. Most of his stories revolved around the fear of abandonment and feelings of

insecurity. There was a need for approval and acceptance. The desire to have a loving father was projected .In all his stories women were portrayed as bad and promiscuous. However he appeared to be strongly drawn to them for nurturance and support. The environment was perceived threatening and insecure. Most of the stories had a tragic ending.

Rorschach – The total number of responses were 11 indicating under productivity. Reaction time was within normal limits for all cards. Most of the responses were animal responses. Colour responses were less. There were no shading or texture responses. Most of the responses were whole responses, with good form level. Width of content was narrow. There were no pathognomonic signs like confabulation, perseveration or contamination. Bizzare responses were absent. Popular responses were present indicating adequate ties with reality.

Conclusion

He was prone to exhibit maladaptive behaviour under stressful situation. His disregard to social norms was also evident. The difficulty in decision-making and problem-solving justify his dissatisfaction with life. The environment was perceived threatening and insecure. Poor interpersonal relations can be the cause of his psychopathology. Rorschach revealed no pathognomonic signs of psychosis or mood disorder.

Final Diagnosis

Dissociative Disorder

Management

Rapport was established with the patient. Patients mother was educated about illness and she was taught to cut down the secondary gains by not giving attention to his symptoms. Principles of differential reinforcement and daily activity scheduling were also used to control the symptoms. Social skills training with focus on helping him to deal with heavy responsibilities and stress was also undertaken. Specific techniques as self-instruction, feedback, and reinforcement of positive interactions were used. IQ was quantified (78 in WISC). He was taught relaxation techniques and coping skills. He had three dissociative episodes in the hospital and was symptom free at the time of discharge. The mother was advised about the need to shift the schooling to an easier board (NOS) as he had academic difficulties.

CASE RECORD 2

Name	: Mr R.K.
Age	: 20 years
Sex	: Male
Marital status	: single
Religion	: Hindu
Language	: Tamil
Education	: Bsc
Socio-economic status	: Middle
Residence	: Rural
Informant	: Mr R.K and his father

Presenting complaints

Poor concentration

Poor academic performance

Anxiety in social situations

Sexual misconceptions

Duration

5 years

History of presenting illness

The patient was described to be a highly reserved and introvert person with less number of friends. He was apparently normal till he reached 10th standard when he noticed to have decreased energy in doing work, poor concentration and easy fatiquability. His academic performance also started deteriorating. He attributes the cause of illness to loss of semen when he masturbates. He expresses guilt regarding masturbation. He would have episodes of anxiety, sweating and palpitation when he think about masturbation. He is worried that this might affect his marital life adversely.

There was no history suggestive of first rank symptoms.

There was no history of any abnormal perception.

There was no history of depressive symptoms.

There was no history of mania or hypomania.

There was no history of phobia or panic attacks.

There was no history suggestive of organicity or seizures.

Treatment history

The details of treatment history were incomplete. He is on various psychotropic medications since 2007, which included fluoxetine 20mg, alprazolam1mg mirtazepine 15 mg. There was no improvement noticed with any of these medications.

Family history

The patient is 3rd among Three siblings. There is family history of OCD with elder brother.

Developmental history

The antenatal period was supervised and uneventful. Delivery was full term normal vaginal; with no birth asphyxia or neonatal seizure. Postnatal period was uneventful. The developmental milestones were reported to be normal.

Educational history

Up to 10^{th} standard he was reportedly average in studies. After 10^{th} standard, his academic performance deteriorated primarily due to the illness.

Sexual development

He had male gender identity. He reported heterosexual orientation. There was masturbatory guilt. He denied any high risk sexual behaviour.

Premorbid personality

He was described to be a reserved and introvert person. He had less social contacts and he had difficulty in making friendships. However he was a responsible and hardworking person with high enthusiasm in studies. There was no history of substance use or manipulative behaviour..

Physical examination

His vitals were stable. Systemic examinations were within normal limits. There were no self-harm marks.

Mental status examination

He was well built and kempt. Eye contact could be maintained. He had a tense facial expression. Rapport was easy to be established. There was no restlessness. His level of activity was normal. There were no abnormal involuntary movements. He was co-operative. His primary mental functions were normal. Attention and concentration could be aroused and was sustained. He had good immediate, recent and remote memory. He was oriented to time, place and person. His speech was of normal tone, pitch, reaction time, speed.

Form and stream of thought were normal. Content of thought revealed distress regarding masturbatory guilt and illness and poor achievement in academics.. No delusions or depressive ideas were elicited. There was no thought broadcast or thought control or thought insertion. There were no perceptual abnormalities. Subjectively, he expressed sad mood. He denied any suicidal ideas. His personal judgement was impaired. His social and test judgements were intact.

Provisional diagnosis

Dhat syndrome

Anxious Avoidant personality traits

Aim for personality assessment

To assess baseline personality and to understand more on psychopathology

Tests administered

1. Sacks Sentence Completion Test
2. 16 PF Questionnaire
3. Draw a Person Test

Behavioural observation

During the entire exercise, he was cooperative. He could comprehend the instructions and paid adequate attention. He appeared well motivated. He was keen on understanding the tests in detail and was probing repeatedly.

Rationale and Findings

16 PF questionnaire measures a set of 16 traits that describe and predict a person's behaviour in a variety of contexts. It aims to provide comprehensive information about an individual's whole personality, revealing potential, confirming capacity to sustain performance in a larger role and helping identify development needs. It is an empirically based tool that helps to remove the subjectivity inherent in the interview or assessment process

16 PF findings

On 16 Personality factor he has scored low on factors B, C and Q3 indicating that he is less intelligent in thinking , usually adapts concrete way of thinking. He is easily affected by feelings, emotionally less stable and gets easily upset. He also follows his own urges , careless of protocol & has undisciplined self conflict. He has scored high on factor N and

Q2 indicating that he is shrewd, calculative, worldly & penetrating. He is also self sufficient , prefers own decisions and is resourceful. On second order factor he scored high score on anxiety (7.5) and independent (5.7) indicating that he is highly anxious in nature and prefers to be independent in decision making & other activities.

Sacks Sentence Completion Test

It is a projective test developed by Dr Sacks and Dr Levy. It consists of 60 partially completed sentence to which respondent adds endings. The respondent projects the attitudes towards a personal experience of life. It helps to elicit ideas of self-perception.

SSCT findings - indicating that he is slow tempered, unenthusiastic, reserved & uninquiring. He is also in less need of stimulation, resistant & slow to engage in new activities and conventional. He also tends to blame other people & external circumstances for what is happening . He feels that his attitudes, behaviour and choices are determined by influences outside their control or against their will.

Draw-a-Person Test is a projective test to indicate personality and person's psychopathology

Findings: The test revealed severe anxiety and poor coping styles. The drawings also revealed somatic preoccupation. There is high sense of importance given to physical appearance and hypervigilance to anxiety.

Conclusion and management

The Tests revealed his personality traits viz. emotionally less stable, and anxious. It also indicated that he is less intelligent in thinking, and usually adapts concrete way of thinking. Tests also found that he is slow tempered, unenthusiastic, reserved & uninquiring. He is also in less need of stimulation, resistant & slow to engage in new activities and conventional. Blaming the outside for his failures were also evident.

Rapport was established with the patient. Dothiepin was started to lessen his anxiety. He was asked to keep a cognitive diary. During interviews the negative automatic thoughts and possible alternative thoughts are discussed. Improvements in his anxiety and positive world view have noticed over a period of time. He was adviced a regular OP follow up visits.

CASE RECORD 3

Name	: Miss.G.K.
Age	: 19 years
Sex	: Female
Marital status	: Unmarried
Religion	: Sikh
Language	: Punjabi
Education	: 12th standard
Occupation	: Currently unemployed
Socio-economic status	: Middle
Informant	: Patient and her mother

Presenting complaints

Episodes of Loss of consciousness

Anger and irritability

Hearing nonexistent voices

Duration

4years

History of presenting illness

From early childhood onwards, Ms.GK was reported to be adamant. She had poor frustration tolerance that even for trivial incidents at school or at home she will be angry

and sometimes agitated. But significant changes were noticed since she was studying in 10^{th} standard. She was noticed to have multiple episodes of loss of consciousness. The episode would last for 5 to 10 minutes. Usually the episodes are preceded by a problem at home or in school. After regaining the consciousness she would resume her routine activities. There was no history of injury, incontinence of urine or bowel during the episodes. For the last 3 to 4 years she also started complaining that she could hear nonexistent voices talking to her. She could hear multiple voices, both male and female, talking to her and talking to each other. She also express the fear that, she feels that somebody is catching her neck from behind and trying to kill her, when nobody is around. There was no history of depressive syndrome or mania or hypomania. There was no history of phobia or panic attacks. There was no history suggestive of organicity or seizures.

Family history

She was the youngest of three siblings. There was no neuropsychiatric morbidity in family.

Developmental history

The antenatal period was supervised and uneventful. Delivery was full term normal vaginal; with no birth asphyxia or neonatal seizure. Postnatal period was uneventful. The developmental milestones were reported to be normal.

Educational history

She had completed 12th standard and joined a nursing course, which she did not continue due to the illness. Her academic performance was reportedly average.

Sexual development

She had female gender identity and heterosexual orientation.

Marital history

She was unmarried

Premorbid personality

She was described to be a sociable, responsible and religious person with good moral standards.

Physical examination

Her vitals were stable. Systemic examinations were within normal limits.

Mental status examination

She was moderately built. She was well kempt. Eye contact could be maintained. Rapport was established without difficulty. Her level of activity was normal. There were no abnormal involuntary movements. Her primary mental functions were normal. Attention and concentration could be aroused and was sustained. She had good immediate, recent and remote memory. He was oriented to time, place and person.

Her speech was of normal tone, pitch, reaction time and speed. Form and stream of thought were normal. No delusions or depressive ideas were elicited. There was no thought broadcast or thought control or thought insertion. There were second person and third person auditory hallucinations. Her mood was euthymic. Her insight was poor and judgment was intact.

Provisional diagnosis

Dissociative Disorder

Paranoid Schizophrenia

Aim for psychometry

1. To clarify symptomatology, psychopathology and diagnosis
2. To identify conflicts that will help in psychosocial intervention

Tests administered

1. Rorshach test
2. Thematic Apperception Test
3. Sacks Sentence Completion Test
4. Draw a person test

Behavioural observation

During the entire exercise, she was cooperative. She could comprehend the instructions and paid adequate attention. He appeared well motivated.

Rationale and Findings

Rorshach Ink Blot Test provides an understanding of structure of the personality, affectional needs and ego strength. It also indicates degree of psychopathology.

Findings

On Rorschach protocol, quantitative analysis was done as it was productive with 25 responses. She meets criteria for hypervigilance index. The lambda value falls above the average range indicating avoidant introversive style ie, she is more disposed to keep feelings at a more peripheral level during a problem solving & decision making. She has a more sturdy tolerance for stress than do most, it does not indicate better adjustment but it simply suggests a greater capacity for volitional capacity. The stress that she experiences interferes with some of her customary patterns of thinking. There is strong evidence that there is presence of stress. Analysis also indicates avoidant introversive style which suggests that she prefers to keep their emotions aside during difficult situations & tends to delay initiating behaviors until she has time to consider various options. She is less willing to process emotional stimuli and her preferences depict limited complexity. She tends to avoid situations that would exacerbate those difficulties. More effort has been invested in processing than might be expected. The probability of failure to achieve objects is increased & the consequent impact of these failures can often include the experience of frustration. There is presence of faulty translation of cues that are present leading to less effective patterns of behavior. Mediational impulsiveness is present.

Thematic Apperception Test is a projective measure intended to evaluate a person's patterns of thought, attitudes, observational capacity, and emotional responses to ambiguous test materials. It elicits information about a person's view of the world and his attitudes toward the self and others

TAT findings:

On TAT analysis her main themes were about a woman who was helpless initially but achieves great things later, becomes famous and helps others. Her main needs were need for autonomy, achievement & affiliation. Her nature of anxieties were deprivation, helplessness, being overpowered. The significant conflicts were support vs. independence, affiliation vs. rejection, autonomy vs. compliance, helpless vs. autonomy. Sex vs. morality. The main defense mechanisms that were used were altruism, reaction formation, projection & sublimation. All the stories has a happy outcome and were realistic.

Sacks Sentence Completion Test is a projective test developed by Dr Sacks and Dr Levy. It consists of 60 partially completed sentence to which respondent adds endings. The respondent projects the attitudes towards a personal experience of life. It helps to elicit ideas of self-perception.

SCT findings:

On SSCT the person has main difficulty in interpersonal areas such as with parents and stressful home environment. He also revealed significant conflicts and disturbances in the

domain of family particularly with parents' marital relationship, future, fears and guilt feeling regarding past.

Draw-a-Person Test is a projective test to indicate personality and person's psychopathology

DAPT findings:

On draw a person test the test indicates that she has faced frustration in spheres of education & intellectual attainment. Large head indicates that there is presence of frustrated intellectual aspirations. She has strong fantasy content & symbolic expression of sexual vitality. Piercing eyes indicates more the function of an aggressive social tool than of esthetic or more comprehensive visual experience. The presence of hair emphasis on the head indicates that she has an expression of the virility conflict brimming over into sexual conflicts. She has drawn an inappropriate face which indicates that she has fears for auto – erotic indulgence. The arms that are drawn are drawn in a single dimension and not away from the body indicating that self incapacitation.

Conclusion and management

The tests revealed her personality traits viz. avoidant, emotional dysregulation, sensitivity to stressors. She was prone to exhibit maladaptive behaviour under stressful situation. No psychosis was evident in the tests conducted. The difficulty in decision-making and problem-solving justify her dissatisfaction with life. The defense mechanisms were mostly mature and neurotic. The significant conflicts were support vs. independence,

affiliation vs. rejection, autonomy vs. compliance, helpless vs. autonomy. Sex vs. morality. She was found to be vulnerable to social rejection. There was also tendency to loss self-sufficiency. Both finally may culminate in somatisation with secondary gain.

Rapport was established with the patient. Patients mother was educated about illness and she was taught to cut down the secondary gains by not giving attention to her symptoms. Principles of differential reinforcement and daily activity scheduling were also used to control the symptoms. Social skills training with focus on helping her to deal with heavy responsibilities and stress was also undertaken. Specific techniques as self-instruction, feedback, and reinforcement of positive interactions were used. She was taught relaxation techniques and coping skills. She had four dissociative episodes in the hospital and was symptom free at the time of discharge.

CASE RECORD 4

Name : Mr .A.K.

Age : 19 years

Sex : Male

Education : 8th std

Occupation : student

Informant : mother

Language : Bengali,Hindi

Handedness : right

Presenting complaints:

Physical and verbal Aggression

Adamancy

Poor memory

Poor academic performance

Decreased sleep

Duration: 2 years

History of presenting illness:

Patient was apparently normal till 10 years back when he suffered from multiple episodes of vomiting, falls, tremors of extremities and loss of consciousness. He was taken to a hospital in Chennai and was diagnosed as hydrocephalus and tectal mass

lesion. Ventriculo-peritonial shunt was done. Later he was referred to CMC, Vellore as shunt block was noticed and VP shunt was again done in CMC. Following the surgery, vomiting, falls and episodes of loss of consciousness had subsided. However the patient was noticed to have poor Academic performance in school, repeated failures, frequent change of school since then.

For the last 2 years a significant change is noticed in patient's behaviour. He had started abusing and assaulting family members and noticed to have a negative attitude towards everything, and accusing others for his problems. He had become more irritable and adamant. He would demand unreasonanbly. He had forgotten his lessons at school and had difficulty in pursuing his academic work. Reading and writing skills had deteriorated. His sleep was also reduced. There was no history of seizures, mood syndrome, anxiety or psychosis.

Birth and Development History:

He was a full term normal delivery at hospital. No perinatal complications were reported. His developmental milestones were within normal limits.

Personal History

He was studying in 8^{th} Std. His performance in school was average. He was a sociable and outgoing person.. His relationship with peers and schoolmates was good. There were no prominent anxiety traits.

Family History:

He is the first of 2 siblings born of a nonconsanguinous union. There is family history of anxiety disorder with two of his paternal uncle and Mental retardation with one cousin brother.

Physical Examination:

His vital signs were stable and systemic examination was within normal limits.

Mental Status Examination:

He was moderately built, adequately kempt. His motor activity was normal. His attention could be aroused and sustained. He was not distractible. His immediate memory was partially impaired. His recent and remote memory was fair. He was oriented to time, place and person. Speech was soft with decrease in tone, volume and tempo. Reaction time was decreased. Content of thought revealed no abnormality. There was no formal thought disorder. He denied any depressive cognition.. He had partial insight into his problems.

Diagnosis

Organic personality disorder

Aim of Psychological Assessment

1. To find out the cognitive profile of Mr AKR
2. To relate the findings to clinical presentation

3. To identify the neuroanatomical and neurophysiological sites of lesion

Tests Administered

1. NIMHANS Neuropsychological Battery

Rationale and findings

NIMHANS Neuropsychological Battery – Developed by Dr C R Mukundan. This tests a subject's performance across lobe functions. It has been validated to suit the Indian adult population. It comprises of a series of tests that test the following functions

Frontal lobe: Attention, scanning, ideational fluency, abstraction, delayed response learning, execution of motor tasks

Parietal lobe: Perceptual (Bender visual motor Gestalt test), visual analysis and synthesis (Block design test), test for spatial relations and tests for parietal lobe focal signs

Temporal lobe: Sentence repetition, comprehension, verbal learning and memory, visual integration (Object assembly test), visual memory (Benton's visual retention test) and visual learning and memory

Behavioral Observation: Patient was alert during testing. He was motivated and cooperative. He was able to comprehend test instructions adequately

Test Findings: On NIMHANS Neuropsychological Battery, his attention could be aroused and sustained for a prolonged period. His performance on tests of scanning, trail making, working memory was adequate. He performed adequately on execution of motor

tasks, kinetic melody and ideational fluency. He performed inadequately on test of abstract ability. There was no motor perseveration evident. His performance on expressive and receptive functions was adequate.

He has performed inadequately on visuo-spatial perceptual functions, spatial relations and visuo-constructive skills as evident on BGT, block design test and as well as on copying of three dimensional drawings. There was no evidence of agnosias, apraxias, body-schema disturbances or any other parietal focal signs.

His comprehension, memory of simple sentences was adequate. However, associate learning ability, visual and verbal learning memory was severely impaired.

Conclusion

Neuropsychological assessment reveals bilateral temporal and right parietal involvement with moderate deficits in prefrontal cortex

Management

Mr AKR and his parents were educated on the nature of illness and, about the assessment results. The distress was acknowledged and, supportive psychotherapy was employed to prevent emotional breakdown. Cognitive retraining in the form of improving memory and attention were initiated. He was helped to structure his daily activities. Academic tasks were initiated gradually. Remedial teaching was recommended.

He was referred to Department of Neurology for evaluation of surgical option. He was advised to review after the procedure to assess the cognitive impact of neurosurgery.

CASE RECORD 5

Name : P.R.

Age : 2 years 7 months

Sex : Male

S.E.S : Middle

Informant : Parents

Reliability : Good

Presenting Complaints:

Difficulty in walking

Delayed speech development

Hearing impairment

Duration of illness – since birth

Precipitating factors – nil

History of presenting complaints:

The patient was born out of a non consanguineous union. It was a preterm (32 weeks) normal delivery in the hospital. There were no perinatal complications. Parents noticed a delay in motor milestones after the age of 1 year. He attained head control at the age of 4 months, turning at 6months, sitting with support at 11 months, standing at 18 months and walking with support at 2 years of age. Likewise his language development was also

delayed. He started cooing at 1 year, babbling by 2 years of age and thereafter no language development was noticed. He started recognizing his mother by 6 months of age and social smile was noticed by around 8 months of age. He was noticed to have hearing impairment and was evaluated by an ENT specialist who confirmed the same.

Past History

Nil significant

Family History

There was family history of depression in paternal grandfather.

Physical Examination

His general and systemic examinations were within normal limits.

Mental Status Examination

The patient was moderately built. He did not make eye contact. He walked around the room by holding onto the chair and table. He showed interest in playing with the toys provided. He did not show signs of separation anxiety.

Provisional diagnosis

Unspecified developmental delay.

Aims of psychological testing

As there was history suggestive of delayed development, inadequate communication and social skills deficits it was appropriate to do a developmental assessment to ascertain his level of functioning.

Tests administered

1. Vineland Social Maturity Scale (VSMS)
2. Gesell's Developmental Schedule (GDS)

Rationale for tests

1. VSMS was used to assess the social adaptation and social age
2. GDS was used to assess his developmental age in the various domains.

Behavioral observations

The patient was not adequately co-operative for the test. He had difficulty in comprehending simple instructions. His attention could not be easily sustained and he was unable to persist on the task.

Test findings

1. **VSMS –** the social maturity of the patient was around 1.75 years, which was below the patient's age. The profile of age levels across the functions was as follows:

Self help general	1.98 yrs
Self help dressing	-
Self help eating	1.85 yrs
Communication	0.93 yrs
Self-direction	-
Socialization	-
Locomotion	1.75 yrs
Occupation	2.03 yrs

2. **Gessell Developmental Schedule**

   Developmental age – 17 months

   Chronological age – 31 months

   Function wise profile:

   Adaptive– 21 months

   Gross motor – 21 months

   Fine Motor – 18 months

   Language – 8 months

   Personal & Social -15 months

The DQ of the patient was 60, excluding language, which indicates mild developmental delay.

Impression

The tests revealed that he had global deficits in all areas .His social maturity was around 1.75 years. The DQ according to the Gessell Developmental Schedule was suggestive of mild developmental delay.

Management

The caregiver was educated regarding patent's problems and prognosis. The parents were advised to train him in toileting, dressing, eating, brushing, bathing and understanding concepts. They were also taught to do task analysis and rewarding techniques. The use of a hearing aid as well as speech therapy was recommended, to improve his language. Parents were advised to admit him in special school for special education and training.